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~~planning services to patients receiving psychiatric care in the exempt inpatient psychiatric unit. Such patients must meet the definitions for care and payment pursuant to this subdivision and section 86-1.57(e) of this Subpart. The enhanced discharge planning add-on shall be made as follows:~~

~~(i) A discharge planning payment of $65.00 shall be made for discharged inpatients eligible for coverage pursuant to Title XIX of the Federal Social Security Act and for whom hospitals have developed outpatient discharge plans and ensured linkage with outpatient providers licensed or certified by the State Office of Mental Health in the following manner:~~

~~(a) the patient's discharge plan shall specify the outpatient provider to whom the patient was referred, and be in the possession of such outpatient provider prior to payment of such discharge planning payment.~~

~~(b) Outpatient psychiatric services shall be rendered to these patients within ten (10) days of hospital discharge as validated by State Department of Social Services Medicaid Management Information Systems (MMIS) adjusted claims data.~~

~~(ii) Discharge planning payments based on claims accrued during the rate period shall be incorporated into the case mix adjusted per diem at the same time as the rate period case mix changes are made pursuant to this subdivision.~~

~~(10) for the period July 1, 1990 through December 31, 1995, the exempt psychiatric unit rate for hospitals phased in pursuant to Section 86-1.57(c)(1) shall not be less than the per diem rate calculated pursuant to Section 86-1.57(c) of this Subpart.~~

~~(d)~~] (c) Volume adjustment for case payment rates.

(1) Rate year volume adjustment.

(i) For any general hospital not meeting the qualifications in subparagraph (ii) of this paragraph, a rate year volume adjustment to the facility's case mix neutral price per discharge shall be made within six months following the rate period for those hospitals meeting the following criteria:

(a) the hospital has experienced a decrease or increase in volume as measured by the net change in total non-Medicare discharges between the rate

year and 1987, including discharges of patient for whom reimbursement is provided on a per diem basis, that is equal to or greater than ten percent; and

[(ii)] (b) the hospital has experienced a decrease or increase in volume as measured by the net change in total non-Medicare case payment discharges between the rate year and 1987 which is equal to or greater than ten percent. For purposes of this subdivision, 1987 non-Medicare case payment discharges shall mean non-Medicare patients who received services in 1987 that would not have been exempt if they had received such services in 1988;

[(iii)] (c) in the case of decreases in volume only, the failure to make a volume adjustment would seriously impact the financial stability of a hospital for which there is a demonstrated public need as determined in accordance with Part 709 of this Title.

(ii) For any general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal Social Security Act (Medicare) or a general hospital qualified as a rural hospital as defined under state law, having less than 201 certified inpatient beds, a rate year volume adjustment to the facility's case mix neutral price per discharge shall be made within six months following the rate period for those hospitals meeting the following criteria:

(a) the hospital has experienced a decrease in volume as measured by the net change in total non-Medicare discharges between the rate year and 1987, including discharges of patients for whom reimbursement is provided on a per diem basis, that is equal to or greater than one percent; and

(b) the hospital has experienced a decrease in volume as measure by the net change in total non-Medicare case payment discharges between the rate year and 1987 which is equal to or greater than one percent. For purposes of this subdivision, 1987 non-Medicare case payment discharges shall mean non-Medicare patients who received services in 1987 that would not have been exempt if they had received such services in 1988;

(c) in addition a volume adjustment shall be made to the facility's 1991 case mix neutral price per discharge on or before July 1, 1991 for such rural hospitals which have experienced a decrease in volume equal to or greater than one percent between 1987 or such subsequent year for which a volume adjustment was made and 1989 and/or 1990 when measured as provided in clauses (a) and (b) of this subparagraph.

(2) The case payment rate shall be adjusted according to the following conditions:

TN 91-6 Approval Date AUG 4 1993
Supersedes TN 89-46 Effective Date JAN - 1 1991

(i) Operating costs shall be considered fixed where there are decreases in discharges. Operating costs shall be considered variable where there are increases in discharges.

(ii) The first rate year volume adjustment to the facility's case mix neutral price per discharge attributable to the facility's change in discharges between the rate year and 1987 shall be made incrementally according to the following steps:

| Decrease in non-Medicare Case Payment Patient Discharges (% Change) | Fixed/Variable Percent | Increase in non-Medicare Case Payment Patient Discharges (% Change) | Fixed/Variable Percent |
|---|---|---|---|
| 0 to 6 | 60/40 | 0 to 6 | 60/40 |
| 6+ | 50/50 | 6+ | 50/50 |

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(3) Revised rate year volume adjustment. If a hospital receives a rate year volume adjustment pursuant to the provisions of paragraphs (1) and (2) of this subdivision, that volume adjustment shall be revised in rate years subsequent to the first year as follows:

(i) if the difference between the hospital's total non-Medicare discharges in the subsequent rate year and 1987 is less than the difference between the hospital's total non-Medicare discharges in the first rate year for which a volume adjustment was made and 1987, then the volume adjustment shall be revised in the subsequent year pursuant to the incremental schedule of paragraph (2), but only for a change in total non-Medicare case payment discharges between the subsequent rate year and the first year for which a volume adjustment was made which exceeds one percent. The volume adjustment shall be revised only until the total non-Medicare discharges in the subsequent rate year are equal to or greater than the 1987 total non-Medicare discharges in the case where a first year volume adjustment was made for a volume decrease; or only until the total non-Medicare discharges in the subsequent rate year are equal to or less than the 1987 total non-Medicare discharges in the case where a rate year volume adjustment was made for a volume increase.

(ii) If the difference between the hospital's total non-Medicare discharges in a subsequent rate year and 1987 is greater than the difference between the hospital's total non-Medicare discharges in the rate year for which a volume adjustment was made and 1987, then a volume adjustment shall only be made for the subsequent rate year pursuant to the provisions of paragraphs (1) and (2) of this subdivision.

(4) For volume increases only, the commissioner shall take into consideration factors which influenced the volume increase when determining the net change

TN 89-46 Approval Date SEP 8 1992
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OFFICIAL



in total non-Medicare discharges and in total non-Medicare case payment discharges pursuant to paragraph (1) of this section. Such factors shall include but not be limited to the closing of a general hospital in the facility's catchment area, the addition by the facility of approved beds, a reduction in the facility's case mix adjusted paitent length of stay for non-Medicare beneficiaries based on a comparison of the rate year to 1987, [and] an increase in case mix complexity after consideration of the impact of improved coding on reported case mix [.] and the existence of a comprehensive affiliation agreement entered into on or after January 1, 1992 to assure continuation of inpatient services in a hospital in a medically underserved area. A comprehensive affiliation agreement shall mean an agreement by a hospital to serve as the primary source of physicians and residents for another hospital. Volume adjustments and revised volume adjustments for volume increases shall be made only using the net change in total non-Medicare discharges identified after consideration of these factors.

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OFFICIAL



86-1.65 Medicaid Disproportionate Share Payments

(a) For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.

(b) Definitions.

(1) Need shall be defined as inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospital from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. Grants received to finance operating expenses, and the income and, where appropriate, principal, from those endowment funds and special purpose funds whose use is restricted to pay for the costs of care provided to those unable to pay, shall also be considered in the calculation of outpatient deficits and inpatient bad debts and charity care. Base year need shall be adjusted for a facility that has entered into a comprehensive affiliation agreement on or after January 1, 1992 to assure continuation of inpatient services in a hospital in a medically underserved area, to incorporate the additional cost of bad debt and charity care associated with patient referrals resulting from the new comprehensive affiliation. To obtain such an adjustment, the facility must provide documentation, acceptable to the Commissioner, that demonstrates and quantifies the additional cost of bad debt and charity care associated with such new patient referrals. This adjustment must be requested and supporting documentation must be submitted in writing by the facility 60 days prior to the rate period for which the base year need being adjusted is used. Base year need for any facility replaced as a primary affiliate through a comprehensive affiliation agreement shall be adjusted by the same amount to reflect savings associated with the decreased cost of bad debt and charity care referrals from a

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OFFICIAL



charity care need shall be added to or subtracted from the base year need until such time as the additional bad debt and charity need becomes part of the base year need. Thereafter unadjusted base year need shall be used for purposes of regional disproportionate share pool distributions in accordance with subdivision (k) of this section.

(2) Targeted need shall be defined as the relationship of need to net patient service revenue expressed as a percentage.

(3) Net patient service revenue shall be defined as net patient revenue attributable to inpatient and outpatient services excluding referred ambulatory services. Need shall be adjusted as provided in this subdivision. Net patient service revenues shall be adjusted for a facility that has entered into a comprehensive affiliation agreement on or after January 1, 1992 to assure continuation of inpatient services in a hospital in a medically underserved area, to incorporate the additional revenues associated with patient referrals resulting from the new comprehensive affiliation. A comprehensive affiliation agreement shall mean an agreement by a hospital to serve as the primary source of physicians and residents for another hospital. To obtain such an adjustment, the facility must provide documentation, acceptable to the Commissioner, that demonstrates and quantifies the additional revenue associated with such new patient referrals. This adjustment must be requested and supporting documentation must be submitted in writing by the facility 60 days prior to the rate period for which the revenue being adjusted is used. Net patient service revenues for any facility replaced as a primary affiliate through a comprehensive affiliation agreement shall be adjusted by the same amount to reflect a reduction in revenues associated with decreased referrals from a former affiliate. The allowable additional or reduced revenue shall be added or subtracted from net patient service revenue until such time as the additional net patient service revenue becomes part of base year net patient service revenue. Thereafter unadjusted net patient service revenue shall be used

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for the purposes of regional disproportionate share pool distributions in accordance with subdivision (k) of this section.

(4) Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in subparagraph (iii) of subdivision (d)(2) of this section.

(5) Targeted need share shall be defined as the ratio of each hospital's nominal payment amount to the nominal payment amounts for all hospitals in the region other than major public general hospitals.

TN 92-36 Approval Date OCT 18 1993
Supersedes TN New Effective Date JUL 1 - 1992

(6) Major public sector hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of $25 million.

(7) Voluntary sector hospitals shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(8) Financially distressed hospitals shall mean those hospitals that meet the criteria specified in section 86-1.66 of this Subpart.

(9) Statewide resources shall mean the sum of the result of multiplying a statewide average 5.48 percent by each general hospital's (including major public hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds. When a prospective adjustment is made to a rate of payment to reflect the retroactive impact of an adjustment in accordance with section 86-1.61(l), no recalculation of disproportionate share payments described in this section shall be made to reflect this prospective adjustment for the prior rate year.

(10) Financially distressed resources shall mean the sum of the result of multiplying [~~.235~~] .325 percent by each general hospital's (including major public hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted for case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without

consideration of inpatient uncollectible amounts, and including income from invested funds.

(11) The regions are established as the article 43 insurance plan regions, with the exceptions that the southern 16 counties shall be divided into three regions with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings Counties; Nassau and Suffolk Counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester Counties. Such regions shall be the same regions established and in effect January 1, 1985. The council with the approval of the commissioner may combine regions, with the exception of the specified regions for the southern 16 counties, upon application of the article 43 Insurance Law plans involved and a demonstration that significant inequities would not occur. Hospitals not participating as of December 31, 1985 in the regional bad debt and charity care pools established pursuant to section 86-1.11(q) and (p) of this Subpart and no longer exempt from the provisions of this Subpart for reimbursement purposes shall be assigned to a region for purposes of determining the disproportionate share payments pursuant to this section. Assignment to a region shall be based upon but not limited to the following factors:

(i) numbers and types of hospitals within the regions; and

(ii) geographical proximity of the hospital requiring such assignment to a particular region.

(c) In order for a general hospital to qualify for Medicaid disproportionate share payments, the general hospital must adhere to the following policies:

(1) To be eligible to receive payments, a facility must meet the criteria specified in section 86-1.11(q)(1) of this Subpart with the following exception. A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must

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